PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		E CONSTRUCTION	(X3) DATE SUF COMPLETI	ED
		17E183	B. WIN	IG			C 0/2012
	OVIDER OR SUPPLIER	ER LTCU	•	РО	ET ADDRESS, CITY, STATE, ZIP CODE BOX 129 JINTER, KS 67752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F	000			
		ns represent the findings of ons #KS00061034 and					
F 272 SS=D	483.20(b)(1) COMPI ASSESSMENTS	REHENSIVE	F	272			
	a comprehensive, ac reproducible assess functional capacity. A facility must make assessment of a res resident assessmen by the State. The as least the following:	aduct initially and periodically ccurate, standardized ment of each resident's a comprehensive ident's needs, using the t instrument (RAI) specified seessment must include at mographic information;					
	Customary routine; Cognitive patterns; Communication; Vision;						
	Continence;	eing; and structural problems; nd health conditions;					
	Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by the Data Set (MDS); and	ummary information regarding sment performed on the care ne completion of the Minimum					
ABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATURI			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E183			11/	C / 20/2012	
	OVIDER OR SUPPLIER	R LTCU	S	ETREET ADDRESS, CITY, STATE, ZIP COE PO BOX 129 QUINTER, KS 67752	•		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 272	Continued From page	e 1	F 27	72			
	by: The facility had a cersampled for review. Based on observation review, the facility fail comprehensive assessummary information assessments perform residents. Resident Symptom CAA (care lacked information reseeking behaviors ide Significant Change Massessment. Findings included: Resident #101's 10 MDS (minimum data the resident had mod The resident had sign which included inatte thinking. The assess had physical behavior toward others and oth directed toward other assessment period. Indicated the resident	regarding additional and for 1 of 3 sampled area assessment) summary lated to the resident exit entified in the 10/23/12 lDS (minimum data set) 1/23/12 Significant Change set) assessment revealed erately impaired cognition. In and disorganized ament indicated the resident ral symptoms of the impaired exident ral symptoms directed the behavioral symptoms not its during 1-3 days of the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		17E183	B. WIN	G_		11/20	0/ 2012
	ROVIDER OR SUPPLIER	RLTCU		F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 272	getting to a potentially Resident #101 require persons for bed mobil He/she used a wheeled Resident #101's 10/2: CAA (care area assess the resident's physical related to his/her diagnosummary described the behaviors, however, for resident's wandering/recent elopement and Resident #101's update plan lacked identificated wandering and exit-set to staff related to prevent was a staff related to prevent was a staff related to prevent was a staff resident #101 went to door and had his/her the door when staff redoor alarm. According to a facility 6:15 a.m., resident #1 whe west event was a staff resident was a feel at the process of the process of the process of the person was a staff resident was a staff resident was a staff resident was a feel at the process of the process of the person was a person was	dangerous place. ed extensive assistance of 2 lity, transfers, and toilet use. chair for mobility. 3/12 Behavioral Symptom asment) summary revealed I condition had declined mosis of cancer. The CAA he resident's "erratic" ailed to address the exit seeking behavior and I fall on 10/12/12. Atted 10/30/12 nursing care ion of the resident's eeking behaviors or direction rention of elopement. 0/12 at 8:00 p.m. revealed the west door, opened the wheelchair halfway out of esponded to the sounding investigation on 10/12/12 at 01 entered a code into the xit door and exited heelchair, tipped over in the at the bottom of the 3 steps eent had a "code alert" eet staff when the resident oor) on his/her ankle which hee light inside of the facility. Inded since the resident ode into the keypad.	F	272			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		17E183	B. WIN	IG			0
	ROVIDER OR SUPPLIER	I		F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/2	0/2012
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F 272	Assessment identified elopement as evident leave the facility and facility on 10/12/12. Nurses' notes on 10/2 the resident attempte west entrance again. resident had the door door when staff responsive to the facility's 10/07 Reprevention Policy and who exhibited or development as sessed and the "carecommend a specific implementation within During an observation resident #101 sat in a by the dining area and dining room for break alert" bracelet on his/ During an interview of administrative nurse nursing care plan lack his/her wandering be Administrative nurse considered exit seeking consideration of the reseking behavior and The facility failed to cassessment which incin resident #101's 10/15 10/15 and to 10/15 10/15 10/15 10/15 and to 10/15 10	d the resident as at risk for ced by recent attempts to successfully exited the 23/12 at 11:20 p.m. revealed d to leave the facility at the The notes further stated the open and headed out of the onded to the alarm. esident Elopement d Procedure stated residents eloped wandering will be are plan team will explan of care for a seven days of the incident". In on 11/15/12 at 7:55 a.m. a wheelchair in the hall way d slowly self-propelled to the fast. He/she had a "code her ankle. In 11/14/12 at 2:49 p.m. B confirmed resident #101's ked information related to havioral symptoms. B stated he/she had not ng as a behavior and ummary lacked esident's wandering/exit I recent elopement.	F	272			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER	R LTCU		1	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272 F 280 SS=D	The resident has the incompetent or other incapacitated under the participate in planning changes in care and A comprehensive car within 7 days after the comprehensive assessinter disciplinary teams physician, a register of the resident, and disciplines as determinant, to the extent pratter esident, the resident legal representative;	ricant Change MDS. (k)(2) RIGHT TO INING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment. re plan must be developed		272 280			
	by:	r is not met as evidenced nsus of 42 residents with 3					
	review, the facility fai	n, interview, and record led to revise 2 of 3 sampled re plans. (#101 and #102)					
	Findings included:						
	- Resident #101's 10	0/23/12 Significant Change					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	
		17E183	B. WIN	IG			0/2042
	COVIDER OR SUPPLIER	L		F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/20	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	MDS (minimum data the resident had mod The resident had sign which included inatter thinking. Resident #1 assistance of 2 persot transfers, and toilet us wheelchair for mobility assessment, the resident mon-injury falls and 1 prior assessment. Resident #101's 10/2 assessment) summar an overall decline in this/her cognition, balaindependently, and his The summary indicate the past month, one for resident attempted to required frequent 1:1 Resident #101's 10/3 included the following preventions: * I am on 30 minute to be free of fall related * I have a pressure ped to alert staff and my wheelchair and or these and hid them in for their presence. * I need help from 2 second preventions only put resident to sleepy (revised on 11 second preventions).	set) assessment revealed erately impaired cognition. It is and symptoms of delirium intion and disorganized 01 required extensive insight for bed mobility, see. He/she used a gy. According to the ident had 2 or more injury fall since the solution of the dent had 2 or more injury fall since the solution of the past month affecting ance, ability to stand is/her awareness of safety. It is in all with a minor injury. The stand on his/her own and attention from staff. 10/12 nursing care plan interventions for fall interventions for fall othecks by staff and I want to injuries. It is ad alarm on the floor by my at a tabs monitor to place in a my bed. I have removed in the past so please check is staff with my sit to stand lift. In bed when he/she seemed	F	280			

Facility ID: H032101

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AND PLAN OF CORRECTION IDE	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
	17E183	B. WIN	G			0/2042
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU			F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/20	0/2012
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280 Continued From page 6 Resident #101's Fall Risk As revealed a score of 14 and of a score of 22, both scores in had a "high risk" for falls. A physical assessment form a fall on 10/11/12 revealed to unwitnessed fall when staff laying on his/her left side be intervention noted on the asstated, "Resident brought to awake". A physical assessment form a fall on 10/18/12 revealed to witnessed fall with the intervence form blank. Review of the number of the	on 10/23/12 revealed adicated the resident andicated the resident andicated the resident and found the resident side his/her bed. An sessment form nurses station while completed following he resident had a rention section of the urses notes for tion of the fall. Colan lacked revision 2. completed following 2 when staff lowered alled this intervention, ation with gadgets to Fall Assessment all, complete the . The Physical an area to document 1/15/12 at 7:55 a.m. chair in the hall way	F	280			

Facility ID: H032101

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	ROVIDER OR SUPPLIER	RLTCU	,	P	EET ADDRESS, CITY, STATE, ZIP CODE O BOX 129 QUINTER, KS 67752	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	During an interview of direct care staff D state alarms while in the whand a tab alarm. He/sa sit to stand lift for the An interview on 11/19 licensed nurse C compass well as a pressure when he/she sat in the further stated when a licensed staff assessed the circumstances of the resident's nursing falls. The facility failed to recare plan with interve The care plan lacked 10/18/12 fall and staff to keep the resident at 10/11/12, 10/23/12, and nursing care plan also use of 2 alarms while wheelchair. Resident #102's 7/(minimum data set) a resident had a BIMS status) score of 11 whimpaired cognition and behaviors during 1-3 period. The resident independently. He/sh	oressure alarm and anti-roll ir. In 11/15/12 at 10:18 a.m., ted resident #101 had 2 neelchair, a pressure alarm she further stated staff used e resident for transfers. In 11/15/12 at 10:18 a.m., ted resident #101 had 2 neelchair, a pressure alarm she further stated staff used e resident for transfers. In 12 at 11:00 a.m. with firmed staff used a tab unit alarm for resident #101 he wheelchair. He/she resident sustained a fall, hed the resident, evaluated the fall,, and should revise care plan to prevent future falls. The revision following the firepeated the intervention at the nurses station on not 11/14/12. The 10/30/12 to failed to reflect the current the resident sat in the sees sees ment revealed the (brief interview for mental nich indicated moderately dexhibited wandering days of the assessment transferred and walked	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION 3	(X3) DATE SUF COMPLETI	
		17E183	B. WIN	IG _			C 0/ 2012
	OVIDER OR SUPPLIER			F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/20	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	for mobility. The resides ince the last assess Resident #102's 10/1 assessment revealed score of 7 which indici impairment without w assessment indicated limited assistance wit room/corridor, transfe used a walker for mol non-injury falls since the Resident #102's 10/1 included this interven my chair and one for myself but please attathem off." The nursin interventions to addres behaviors identified of a "code alert" brack when the resident applied for resident #102, the device since 2/15/12. The facility's 10/07 Reprevention Policy and who exhibited or development as specific implementation within During an observation	dent had 1 non-injury fall ment. 6/12 Annual MDS the resident had a BIMS ated severe cognitive andering behaviors. The I the resident required had walking in his/her arred independently, and bility. He/she had 2 or more the prior assessment. 6/12 nursing care plan ation, "I have a tabs alarm for my bed. I take them off ach them to me if you see a g care plan lacked ass the resident's wandering and the 7/31/12 MDS and use alet (device to alert staff broached an exit door). The alert" (device to alert staff broached an exit door) log resident wore a "code alert" The sident Elopement are plan team will plan of care for a seven days of the incident". The on 11/14/12 at 1:40 p.m. ated independently with a	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		ISTRUCTION	(X3) DATE SUF	ED
		17E183	B. WIN	G			C 0/2012
	ROVIDER OR SUPPLIER	R LTCU		ро вох	DDRESS, CITY, STATE, ZIP CODE 129 ER, KS 67752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309 SS=D	attempted to exit. An the resident pushed of wore a "code alert" bit The blue strobe light Direct care staff E reschecked the "code aleran to the west activit staff E re-set the "code intervening and redirect the exit door. During an interview of direct care staff D ide elopement risk and stalert" bracelet on the further stated the residented as the resident's cond. An interview on 11/12 administrative nursed as the resident's wandering or direction to staff reelopement. Administ the care plan needed no longer used a tab when he/she sat in hit. The facility failed to recare plan with interverse Resident #102's nurs	audible alarm sounded as on the door. The resident racelet on his/her right ankle. Illuminated in the corridor. Sponded to the alarms, ert" panel in the hallway and y room door. Direct care de alert" bracelet after ected the resident away from an 10/15/12 at 10:18 a.m., ntified resident #102 as an eated he/she wore a "code ankle. Direct care staff D dent ambulated her room. He/she stated at ab alarm on the resident dition had improved. 1/12 at 2:49 p.m. with B confirmed resident #102's ked identification of the and exit-seeking behaviors lated to prevention of rative nurse B also stated revision to reflect that staff alarm for resident #102 s/her chair. 1/12 evise resident #101's nursing ntions to prevent future falls. Ing care plan lacked revision a tab alarm and his/her risk		309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		NSTRUCTION	(X3) DATE SUF	ED
		17E183	B. WIN	G			C 0/2012
	OVIDER OR SUPPLIER	R LTCU		PO BOX	DDRESS, CITY, STATE, ZIP CODE X 129 ER, KS 67752		0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	provide the necessar or maintain the highe mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical,	F	309			
	by: The facility had a cersampled for review. Based on observation review, the facility fail residents with the neattain or maintain the and mental well-being comprehensive asset (thorough nursing as neurological checks a residents #101 and #Findings included: Resident #101's 10 MDS (minimum data the resident had mod The resident had sign which included inatte thinking. Resident #101's 10 assistance of 2 persot transfers, and toilet u wheelchair for mobility indicated the resident.	after unwitnessed falls) for 103. 2/23/12 Significant Change set) assessment revealed terately impaired cognition. In and symptoms of delirium and disorganized 101 required extensive ons for bed mobility, se. He/she used a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SUF	ED
		17E183	B. WIN	G			C 0/2012
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER	RLTCU	.	РО	ET ADDRESS, CITY, STATE, ZIP CODE BOX 129 IINTER, KS 67752		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 309	assessment) summar an overall decline in this/her cognition, bala independently, and his The summary indicate the past month, one fresident attempted to required frequent 1:1 Resident #101's 10/3 included the following preventions: * I am on 30 minute to be free of fall related * I have a pressure pode to alert staff and my wheelchair and or these and hid them infor their presence. * I need help from 2 : * Only put resident to sleepy (revised on 11 * Sit at nurses' statio activity or food/drink (The physical assessment follow-up neurological assess the initial assessment follow-up neurological nurses' notes on 9/24 resident #101 on the	3/12 Falls CAA (care area by indicated the resident had he past month affecting ance, ability to stand s/her awareness of safety. The ed the resident fell 6 times in all with a minor injury. The stand on his/her own and attention from staff. 0/12 nursing care plan interventions for fall checks by staff and I want to injuries. ad alarm on the floor by my a tabs monitor to place in my bed. I have removed the past so please check staff with my sit to stand lift. The bed when he/she seemed (9/12). In in wheelchair and provided revised on 11/14/12). The past form completed sed fall on 9/24/12 revealed sed fall on 9/24/12 revealed sement done at the time of	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E183	B. WIN	IG		C 11/20/2012		
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTEI	RLTCU		F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE			
F 309	form following an unwarevealed a lack of corchecks after the fall. notes on 10/11/12, stifloor laying beside his vital signs and completransferred the reside brought the resident to the completed physic following an unwitnes revealed a lack of door blood pressure, pulse According to the nurs an alarm and found remat on his/her knees signs" taken without of Review of the Vital Sidocumentation of vital the facility's 3/13/12 directed staff to complete assessment form, near monitor blood pressur respirations, and oxygodining an observation resident #101 sat in a by the dining area and dining room for break but did not respond vitab alarm in place as and anti-roll bars on the control of the	assessment vitnessed fall on 10/11/12 inpletion of neurological According to the nurses' aff found the resident on the sher bed. After obtaining etion of an assessment, staff int to a wheelchair and to the nurses' station. Cal assessment form sed fall on 11/14/12 indicated "vital documentation of the resident's estant and to the notes indicated "vital documentation of the results. It is gins for 11/14/12. Fall Assessment policy lete the physical urological assessment, re, temperature, pulse, gen saturation levels. In on 11/15/12 at 7:55 a.m. wheelchair in the hall way do slowly self-propelled to the fast. He/she remained alert, erbally. The resident had a well as a pressure alarm the wheelchair.	F	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF _DIN(PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER	RLTCU		F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		.D BE	(X5) COMPLETION DATE
F 309	should be performed resident's fall and the cognitive ability to say during the fall. The facility failed to processary care and sethe highest practicable well-being when licent complete thorough nurincluding neurological. Resident #103's 9/4 MDS (minimum data sethe resident had sever required extensive as transfers, walking in resident had no falls set sessment) summare "high risk" for falls. The appointment with his/new order for a medic (irregular heart rhythmassistance of 2 staff of imbalance, and decreed the required extension of the toilet by staff. The appointment with his/new order for a medic (irregular heart rhythmassistance of 2 staff of imbalance, and decreed the required extension of the toilet with his/new order for a medic (irregular heart rhythmassistance of 2 staff of imbalance, and decreed the required extension of the resident #103's 9/11/falls included the follows a wheelchair for regular heart for resident #103's 9/11/falls included the follows a wheelchair for regular heart for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a wheelchair for resident #103's 9/11/falls included the follows a whee	and neurological checks if no one witnessed the resident lacked the resident lacked the right if he/she hit their head roved resident #101 with ervices to attain or maintain e physical and mental sed nursing staff failed to ursing assessments checks following falls. If 12 Significant Change set) assessment revealed rely impaired cognition, sistance of 2 persons for foom, and toilet use. The since the prior assessment. 2 Fall CAA (care area y identified the resident as the summary indicated the 8/9/12 with no injury when the floor during a transfer to the resident had an the physician and received a station for atrial fibrillation in). The resident required lue to his/her instability, ased cognition.	F	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E183	B. WIN	IG_		C 11/20/2012	
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER			F	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/20	0/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	9/14/12) * Tabs monitor (update The completed physic following an unwitness revealed neurological applicable". Accordin 10/30/12 revealed state west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the residence of the west door. After a staff assisted the resident and oxygon assessment form, neuronitor blood pressurespirations, and oxygon on the west door assessment with a self-propelled in the fawore rubber soled slip on while in the wheeled on the west door assessment with vital when a resident falls should be performed resident's fall and the cognitive ability to say during the fall. The facility failed to proceed the highest practicable well-being when licencomplete thorough number of the west door.	cal assessment form sed fall on 10/30/12 checks marked as "not g to the nurses' notes on aff found resident #103 by assessment and vital signs, dent to his/her bathroom. Fall Assessment policy lete the physical urological assessment, re, temperature, pulse, gen saturation levels. In on 11/14/12 at 4:28 p.m., wheelchair and acility hallway. The resident opers and had a tab alarm chair. In 11/19/12 at 11:06 a.m. firmed a nursing signs should be completed and neurological checks if no one witnessed the resident lacked the resident lacked the of the/she hit their head.	F	309			

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILI		-	С	
		17E183	B. WING	§	11/20/2012		
	OVIDER OR SUPPLIER	ER LTCU		STREET ADDRESS, CITY, STATE, ZIP O PO BOX 129 QUINTER, KS 67752	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 323 SS=E	HAZARDS/SUPER' The facility must en environment remair as is possible; and of		F3	323			
	by: The facility had a c sampled for review. residents as "at risk Based on observation review, the facility facility for environment remain as possible for 11 refor elopement when adequately monitor alarms and the "cooksystem. Residents"	on, interview, and record alled to ensure the resident ned free of accident hazards esidents identified as at risk					
	(minimum data set) resident had a BIMS status) score of 9 w impaired cognition. wandering behavior assistance of 2 pers	3/14/12 Quarterly MDS assessment revealed the 6 (brief interview for mental hich indicated moderately The resident had no as and required extensive sons for bed mobility, use. He/she had functional					

Facility ID: H032101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		17E183			C 11/20/2012			
	ROVIDER OR SUPPLIER	ER LTCU		STREET ADDRESS, CITY, STATE, ZIP CO PO BOX 129 QUINTER, KS 67752	DE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 323	limitations in range extremities and use The resident had 1 assessment. Resident #101's 10/MDS assessment remoderately impaired signs and symptom inattention and diso assessment indicate behavioral symptom other behavioral symptom other behavioral symptom others during 1-3 da The assessment als wandering behavior significant risk of gedangerous place. Fextensive assistance mobility, transfers, a wheelchair for mobility assistance assistance assistance assistance. The sident #101's 10/GAA (care area assistance) the resident's wandering recent elopement and the sident #101's 10/Gassessment) summan overall decline in his/her cognition, basindependently, and The summary indicated to his/her cognition, basindependently and the summary indicated to his/her cognition, basindependently and the summary indicated to his/her cognition h	of motion in both lower d a wheelchair for mobility. minor injury fall since the prior 2/23/12 Significant Change evealed the resident had d cognition. The resident had so of delirium which included reganized thinking. The ed the resident had physical has directed toward others and mptoms not directed toward ays of the assessment period. So indicated the resident had so that placed the resident at atting to a potentially Resident #101 required e of 2 persons for bed and toilet use. He/she used a lity. 2/23/12 Behavioral Symptom essment) summary revealed cal condition had declined agnosis of cancer. The CAA the resident's "erratic", failed to address the g/exit seeking behaviors and	F3	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183	B. WIN	IG		C 11/20/2012	
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER	RLTCU		P	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	11/20	0/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	resident attempted to required frequent 1:1 Resident #101's 10/3 included the following preventions: * I am on 30 minute of be free of fall related to free of fall related to alert staff and my wheelchair and or these and hid them in for their presence. * I need help from 2 staff and information their presence to sleepy (revised on 11 to sle	stand on his/her own and attention from staff. D/12 nursing care plan interventions for fall checks by staff and I want to injuries. ad alarm on the floor by my a tabs monitor to place in my bed. I have removed the past so please check staff with my sit to stand lift. bed when he/she seemed /9/12). In in wheelchair and provided revised on 11/14/12). In the total discovery control of the resident's eaking behaviors or direction rention of elopement. Risk Assessment on 8/14/12 and on 10/23/12 revealed ores indicated the resident alls.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183	B. WIN	G		C 11/20/2012	
	ROVIDER OR SUPPLIER	RLTCU	'	P	REET ADDRESS, CITY, STATE, ZIP CODE TO BOX 129 QUINTER, KS 67752		
(X4) ID PREFIX TAG	(ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	exit door) since 7/19// "code alert" bracelet a doors should lock dov strobe lights in the fac located in the hallway activated the alert as involved. Nurses' notes on 10// resident #101 went to door and had his/her the door when staff re door alarm. Apparen activated the blue ligh west door. According to a facility 6:15 a.m., resident #1 keypad by the west e independently in a wh wheelchair, and fell a by the exit. The reside bracelet (device to ale approached an exit de activated the blue stre at 6:13 a.m. when the exit door. No audible resident entered the co Direct care staff F rep beeping sound when and followed the sour and found the resider pressure alarm in the beeping sound. Direct resident entered the co resident at 6:23 a.m. located at the exit. Vi resident entered the co	approached an exit door, the wn with activation of blue cility hallways. Panels is identified the resident that well as the exit door. 10/12 at 8:00 p.m. revealed the west door, opened the wheelchair halfway out of esponded to the sounding tly, the "code alert" bracelet in but failed to lock down the investigation on 10/12/12 at 101 entered a code into the interest at door and exited ineelchair, tipped over in the interest at "code alert" ert staff when the resident poor) on his/her ankle which obe light inside of the facility is resident approached the alarm sounded since the correct code into the keypad. Forted hearing a faint going to the west exit door.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183			C 11/20/2012	
	ROVIDER OR SUPPLIER UNTY MEDICAL CENT	ER LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	•	120/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	the elopement, the registered at 39.9 d resident sustained at to the back of his/he surveillance, the resident entered when direct care sta Corrective action by the door alarm code Nurses' notes on 10 the resident attempt west entrance agair resident had the dodoor when staff resident had the dodoor when staff resident approawearing a "code ale The facility's 2/28/1 Policy and Procedu will be checked by Monday through Fritesting will be comp Coordinator, MDS robesignee], or DON door test procedure approach the door ylock. Attempt to put (without keying in the locked. Document to Maintenance."	ed the resident. At the time of ambient temperature egrees F. (Fahrenheit). The a 1.3 cm (centimeter) abrasion er head. According to video sident remained outside of the of 8 minutes from the time of the code into the keypad and aff F discovered the resident. The facility included changing es. 2/23/12 at 11:20 p.m. revealed the to leave the facility at the facili	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2 IDENTIFICATION NUMBER: A.			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	17E183			C 11/20/2012			
	ROVIDER OR SUPPLIER	RLTCU	<u> </u>	Р	REET ADDRESS, CITY, STATE, ZIP CODE TO BOX 129 QUINTER, KS 67752	11/2	0/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE	
F 323	checked the resident' 11/5/12, 11/6/12, and nurse A checked the period of 7 days occurchecking the device. The facility's revised Elopement Prevention stated, "The door alaweekly. Testing will instaff's response to the Review of the Code Afthe exit doors reveale 9/14/12 until 10/1/12 checking the exit door During an observation the middle west exit dafter pushing on the seconds. A sign on the seconds." During an observation the south west exit door seconds."	l administrative staff G s device on 11/1/12, 11/7/12. Administrative device on 11/14/12. A rred without facility staff October 2007 Resident in Policy and Procedure im system will be tested include alarm functions and e alarms." Alert Check Log that listed in a period of time from with no documentation of irs, a period of 18 days. In on 11/14/12 at 1:56 p.m., aloor failed to alarm or open door handle for over 15 in e door stated, "Push until on the door handle for over 15 in the door stated, "Push until on the door stated, "Push until	F	323			
	adjusted the middle v doors so the doors al seconds of pressure	est and south west exit armed and opened after 15					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183	B. WIN	IG		C 11/20/2012	
	ROVIDER OR SUPPLIER	RLTCU	,	P	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752		
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F 323	checked all of the exit system and confirmed. During an observation resident #101 sat in a by the dining area and dining room for break alert" bracelet on his/li During an interview of administrative nurse of the facility that wore identified them as "at the facility that wore identified them as "at the facility of check of the distribution of the control of the	d doors and "code alert" d they functioned properly. In on 11/15/12 at 7:55 a.m. wheelchair in the hall way d slowly self-propelled to the fast. He/she had a "code her ankle. In 11/14/12 at 1:50 p.m. A identified 11 residents in code alert" bracelets and crisk" for elopement. In 11/14/12 at 3:40 p.m., stated he/she had the king the door alarms and Administrative staff G stated oors and "code alert" hrough Thursdays. Staff G ed absent from work on and did not know if anyone	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183		ıG		C 11/20/2012	
	OVIDER OR SUPPLIER	R LTCU	•	POI	T ADDRESS, CITY, STATE, ZIP CODE BOX 129 NTER, KS 67752	•	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	alert" device activated door should lock dow they had some probled down a few weeks agadjusted the doors so Administrative nurse checked the "code al 4:00 p.m., the doors system activated. The facility failed to environment remained as possible for 11 restor elopement when the adequately monitor the alarms and the "code system. Resident #"	d the blue strobe, the exit n. He/she further stated ems with the doors locking go and maintenance staff to they locked down properly. A confirmed when he/she ert" system on 11/14/12 at locked down when the nsure the resident d free of accident hazards sidents identified as at risk he facility failed to ne functioning of exit door	F	323			